MALPRACTICE INSURANCE POLICIES*

A physician's application for a physician's indemnity or liability policy of insurance, or for any other kind of insurance for that matter, is the foundation stone of the validity of the insurance contract. The insuring company's knowledge of the risk it is assuming is derived from the application.

A physician's statements and representations contained and set forth in the physician's answers to the questions in the application blank regarding his practice; his specialty, if any; the extent of his use of radium or x-ray; the number, qualifications, duties, and responsibilities of his assistants; whether or not he is practicing in copartnership; and all other information requested by the company, as shown by its application blank, should *always* be *full, correct,* and *accurate.*

A malpractice insurance *broker* (and a *broker* usually solicits a physician's business) is *not* a representative of the insurance company. He is the physician's representative.

An *agent* represents the insurance company, and, commonly, an *agent* cannot waive or vary an insurance company's requirements regarding its applications or any clause of its policies.

Therefore, what a physician allows a *broker* to put in the physician's application is the physician's act, and the physician is responsible for any inaccuracies or misinformation which the application may contain when it reaches the insurance company's agents and representatives.

1. A physician should never sign an application blank leaving it to someone else to fill in the answers.
2. A physician should never sign an application blank without reading all the questions and all the answers carefully.
3. A physician should always read the company's blank forms which may be submitted by a broker, and if the physician is in doubt as to any material point, should ask the broker to write to the company and show the answer of the company's representative in reference to the point involved.

FINAL REPORT OF THE COMMISSION ON MEDICAL EDUCATION†

THE PROBLEM OF MEDICAL CARE

The problem of medical care is exceedingly complex. Before substantial progress can be made toward its solution it will be necessary to secure a reasonably clear definition of the present and probable needs of the immediate future for medical services. These vary considerably in the different sections of the country because of local conditions. . . .

THE PRESENT SITUATION

A number of studies by insurance companies, public health organizations, industrial firms, and others indicate that there are about 130,000,000 cases of disabling illness in the United States each year. If nondisabling illness is considered, the figure is about double. Throughout the year an average of about two per cent of the population is incapacitated from illness and twice as many are impaired and handicapped.

The time lost because of illness averages between seven and nine days per employed person and represents about three per cent of the usual working year. It is estimated that the 36,000,000 wage-earners in the country lose about 250,000,000 work-days, and the 24,000,000 school children lose about 175,000,000 days in school each year from illness. The financial loss to the country as a whole represented by the lost earning power and reduced production totals well over two billion dollars a year, equivalent to one-half the cost of maintaining the national government. The economic features associated with preventable and premature deaths represent a further very large sum. The number of work-days and the amount of wages lost because of illness, while very large, are far exceeded, however, by casual and enforced idleness from other causes. It has not been possible to keep the healthy people employed fully even in times of prosperity. . . .

CURRENT TRENDS IN MEDICAL PRACTICE

Current medical practice has taken on certain characteristics which resemble those of contemporary industrial life. Considerable emphasis is being placed upon organizations as a means of providing mass production in medical services. Efforts are made to standardize procedures partly as a reflection of methods in the field of industry. These efforts are based in many instances upon the fundamental fallacy that the human being, who is the unit of medical service, can be regarded as a uniform, standardized organism. The contrary is known to be the case inasmuch as no two individuals are alike, and no two even with the same disorder react in exactly the same way. Sound medical practice requires careful study of the health needs of each individual—physical, psychic, and social. . . .

SPECIALIZATION

Partly because of the skill required in the use of certain instruments, undue emphasis has been given to the various specialties, a number of which have been developed around technical procedures. There has been an extensive subdivision of labor in the field of practice which requires that group and collective opinions be sought in the diagnosis and treatment of some patients. This subdivision of labor, however, has gone beyond the actual needs of the community and most patients. It has been greatly overdone, especially in the large cities. . . .

THE INCOMES OF PHYSICIANS

Most of the emphasis in recent public discussions of the economic aspects of medical care has been upon the cost to the patient and his family. Frequently the impression is created that physicians are securing an economic advantage at the expense of the public. Not over one-third of the expenditures for medical care is for physicians. The mean income of the doctor is low when consideration is given to the investment of time and money in his training. The risks and uncertainties of practice, the expenses of maintaining proper facilities for practice, and the dependence of his income upon his health and vigor make the economic problem of the average physician precarious, especially in the light of the recent growth of community programs of medical service which often are in competition with him.

Studies indicate that even in recent prosperous times 50 per cent of the physicians in the country received an annual gross income of $3,800 or less. About 25 per cent of them received $2,300 or less and 65 per cent received less than the median gross income of about $8,000 (net of about $5,000) for the entire profession.

These income data vary considerably with the size of the community and the type of practice. Communities with a population of five thousand or less represent about 48 per cent of the population and contain 30 per cent of the physicians. The latter receive only 18 per cent of the total estimated income of the profession. Many persons in the smaller communities and suburbs, especially those able to pay for higher medical fees, go to the cities for medical services. This has an important bearing on the distribution of physicians. The studies support common knowledge that the specialists secure a much larger part of the total income of the profession proportionately than the general practitioners. It is estimated that they obtain 40 per cent of physicians' fees, although they represent only 23 per cent of the total number of doctors. General practitioners, representing

* Editor's Note.—The above is an excerpt from a letter sent to all members of The Medical Society of the State of California by order of its board of trustees, prepared by Hartley F. Peart, general counsel. Deeming the matter of particular importance to all members of the California Medical Association, the above excerpt is here reprinted.

† For editorial references to excerpts from the Report, as here printed, see that department in this issue, page 112.

56 per cent of physicians, receive 38 per cent of the income of the profession. The "partial specialist" occupies intermediate ground.

Specialization has developed rapidly partly because the public is willing to pay higher fees for such services. The oversupply of physicians and the general acceptance of more or less standardized fees for the general practitioner, which he is not able to increase materially, tend to force physicians in competitive practice into those fields which promise the largest return for their efforts and in which there are the fewest competitors. The medical needs of the community should ultimately determine the relative numbers of different types of practitioners, rather than the unreliable selection and employment of physicians and others by laymen who have no basis on which to judge the value or indications for different kinds of study and treatment, but who form their opinions often in the belief that the most expensive service should be the best.

THE ECONOMICS OF MEDICAL CARE

Owing to the widespread publicity and propaganda regarding the economic aspects of medical care, the impression has been created that the cost for the country is unreasonably high. . . .

The economic problem of sickness may be stated briefly. Sickness is widespread in most communities and frequently arises from the contacts of everyday life. The risks are so uncertain that an individual can measure the probabilities only in a very general way. It is well known from numerous studies that a large proportion of illness does not receive proper attention and much receives none at all. This is particularly true of those who have a low income in communities which do not have public clinics and hospital services. It is also well known that sickness and consequent disability are important factors in poverty and dependency.

The total direct expenditures for medical services of all kinds are probably not greatly in excess of two and one-half billion dollars per year, representing a little over three per cent of the national income in normal times and about $100 per family per year. As one would expect, these estimates for the entire population are somewhat above those reported in studies of special groups of workers a few years ago which indicated that the average annual amounts spent by families for medical care were about $60 for wage-earners, about $62 for farmers, and about $80 for office employees. A recent study shows that for families with incomes under $1,200, the average expenditures were $66 in 1928. For those with incomes under $2,000, they were $71.48, and for those with incomes between $2,000 and $3,000, they were $102.76. These expenditures are from four to five per cent of the average incomes in each group.

About seven hundred million dollars of the total is spent for medicines of which nearly 75 per cent is for self-medication, largely through patent medicines, and home remedies supplied by the 60,000 drug stores of the country. The total for cult practitioners—osteopaths, chiropractors, naturopaths, Christian Science healers, and other groups—is probably about one hundred and fifty million dollars. Medical, hospital, and public health activities supported by taxation cost about four hundred million dollars a year.

While these expenditures are large, they are of particular significance only when compared with other items of national expenditure in considering the ability of the people to pay for adequate medical care. Those for education as well as those for legal agencies are approximately as large as those for health. At the height of the recent prosperity our annual expenditures for passenger automobiles, noncommercial use of gasoline, tobacco, candy, cosmetics, soft drinks, toys, jewelry, and amusements totaled over twelve billion dollars, more than five times the direct expenditures for medical care. They were made largely by persons of moderate means for whom the cost of medical, dental, nursing, and hospital services are most pressing. The amount spent each year for tobacco alone is about twice the total gross income of all physicians. The amount spent on candy is more than twice that expended on civil hospitals, and that spent for cosmetics is about twice the expenditures for nursing. These items are cited only to indicate that the public can probably afford to pay for medical services.

The public buys what it is taught to buy, and manufacturers spend between one and two billion dollars a year in that instruction by means of advertising. When the public is convinced of the value of proper medical care, there should be no difficulty in financing an adequate program of medical services, although it may mean curtailing to some extent the expenditures for nonessentials.

CONCLUSIONS

Inasmuch as health is the greatest asset of the nation as well as of the individual, those qualified by training and experience have the responsibility of formulating sound programs of medical care and of guiding public opinion aiming to improve and conserve that asset.

Information now exists which gives a reasonably clear definition of medical needs in various communities and the extent to which present efforts meet them. Experience has shown what facilities and personnel are required. A variety of programs have been developed to serve local conditions. The costs are known.

The next steps are the proper coördination of present isolated efforts, the elimination of unnecessary competition and duplication, the development of schemes for distributing the economic burden of sickness, and the education of each community to support an adequate and sound program of medical and public health services.

There is urgent need in many communities for sound regional planning by competent medical and community leaders to secure, distribute, and coördinate local facilities and trained personnel through hospital centers, home nursing and medical services, public health activities, and other features now recognized as essential. Hospital centers provide the professional and community interests and a type of organization well suited to the development of community health programs in many places.

The widespread publicity and propaganda regarding the economic aspects of medical care have focused attention upon the present forms and costs, rather than upon a plan which will insure services of high quality. They have created the impression that the present cost of the care of the sick is unreasonably high. The total expenditures are a small fraction of the national income and insignificant when compared with the vital values which the services aim to protect.

If a high quality of medical care is to be made more universally available, the total expenditures from private and public sources will have to be increased, even after making due allowance for the elimination of wastes and ill-advised expenditures which exist at present. Health services have not secured their full share of the increased "optional consumption" of the country as a whole in competition with commercial appeals for the consumer's income.

Many persons, particularly in the lower income groups, do not receive as much medical attention as they need and cannot be expected to pay for proper care. It is impossible to expect that the highest professional services can be provided in every community or for everyone in any community, but each area should have basic provisions which will meet most of the needs. Proper planning will provide specialized services in near-by centers for those persons who require them.

The plan for a community should be formulated on the basis of medical needs, not on the ability of individuals to pay. The present distribution of medical facilities and personnel is determined largely by economic factors.

The essential feature of a well-conceived program is the quality of the service rendered. The organiza-

tion and the methods of financial support should be formulated to improve and maintain that quality, not merely to provide a service at low cost.

A competent and effective scheme is dependent upon a body of trained personnel who are abreast of current knowledge and skillful in its application. Any plan of organization, whether developed from within the profession or imposed upon it from without, which lessens the responsibility of the trained physician or denies him the rewards of superior ability and character will, in the long run, be detrimental to the public welfare. No scheme of organization or group responsibility can substitute for the priceless, discriminating, and sympathetic judgment of the competent and conscientious physician.

Inasmuch as the objectives of medical care can be attained only by trained personnel, the educational features become paramount, not only in the recruitment and training of students for the professional groups but also in the continuation education which will keep the members of these groups abreast of new knowledge and methods.

The present oversupply of physicians in this country is likely to lead to unnecessary services, to a lowering of the quality of medical care, and to excessive costs because people are not able to judge their needs in such a highly technical field as medicine.

Allowing for the defects in present methods, there are fundamental advantages in the American form of practice which need to be strengthened. It is not necessary to substitute for the present efforts a paternalistic plan ill adapted to the philosophy of American life, but rather to encourage the evolution of a pattern which will embrace the desirable features of our present methods and the correction of their defects.

Some efforts are being made to provide standardized services on a mass production basis, reflecting recent practices in industry. It is a fundamental fallacy to base any program upon the assumption that the human being, who is the unit of practice, can be, or is likely in the future to become, a uniform, standardized organism.

Sound medical care requires that the physician understand the importance and influences of social, economic, and psychological factors as they contribute to the causation, treatment, and prevention of disease in the individual.

The increase of knowledge and technical procedures has made a division of labor within the profession inevitable and desirable. The tendency to partition practice into organs, systems, and techniques, however, with consequent dispersion of responsibility for the patient as a whole, not infrequently turns out to be unnecessary, costly, and misleading.

Specialism has developed beyond the actual needs in the larger communities because it is easier, more satisfying, more highly regarded by the public, and more lucrative than general practice. There is great need of a wider appreciation on the part of the public as well as the profession of the important function of nonspecialized practice and of the fact that only the physician, not the patient, can determine when and what specialist is required.

Specialization and the utilization of a wide variety of nonmedical personnel, institutions, hospitals, and community agencies require collective and group responsibility for the care and treatment of certain patients.

Industrial medicine, group practice, the collective purchase of medical services through various forms of insurance, and the activities of public health departments, hospitals, clinics, schools, workmen's compensation laws, and local, state, and national governments are among the most prominent efforts to provide treatment and care for a large part of the population and to adapt those services to changing professional and social conditions. Some of these activities are in fields regarded in the past as the domain of private practice.

Economic factors such as the capital requirements and maintenance of hospitals, laboratories, and public health projects have brought community financial interests into the practice of medicine. Although specialized institutions, equipment, and technical personnel are needed for certain patients, the public has been led to demand and many practitioners recommend some services which are unnecessary and often costly. . . .

Inasmuch as medical education is primarily concerned with the qualifications and preparation of students to practice medicine, it is highly important that the training be permeated with an understanding of the larger social and economic problems and trends with which medicine must deal, and which are likely to influence the form and opportunities of practice in the future. The type of student who studies medicine is determined to a considerable degree by the professional opportunities and social recognition of the physician.

Although physicians represent only about ten per cent of the personnel engaged in the health program of the country, most features of this essential enterprise should be under responsible medical supervision and guidance. Physicians need to be competent to organize and guide the work of subsidiary professional and nonprofessional aides, if they are to make their maximum contribution toward a satisfactory program of medical services for the country.

The preparation of students for the newer obligations and opportunities of the profession requires a sound training in the principles of the basic sciences, which are likely to remain the foundation of medical practice, research, preventive medicine, and public health work. The training should emphasize, however, that the forms and methods by which these principles are to be applied in meeting the needs of individuals and the community are likely to be modified in the future.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VI, No. 2, February, 1908

From some editorial notes:

Internal Medicine.—Confronted with the fact that there are a good many very excellent papers written on subjects related to internal medicine, but which, either because they are too long or because they are too technical, or for some other reason are not well suited for publication in a general medical journal, such as the *Journal of the Amercan Medical Association,* that association has established a new periodical entitled *Archives of Internal Medicine.* . . .

The Plague Situation.—On December 28, a meeting of the council of the state society was called for the purpose of considering the presence of plague in California and whether or not the state society could do anything to aid in the fight against it. . . .

Up to the end of January there has been no case of human plague in San Francisco for about a month, though the percentage of infected rats has risen steadily until it is over one and one-half per cent. This seems small until one remembers that even in severe epidemics the percentage of infected rats does not exceed six or seven per cent of those examined, and has been as low as two per cent. The Public Health and Marine Hospital Service laboratory is being enlarged and will soon be in a position to examine all rats obtained. Fleas are very scarce in the city, owing to the cold and rainy weather, and that accounts for the falling off of cases of human plague.

* This column strives to mirror the work and aims of colleagues who bore the brunt of society work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and recent members.